

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005352

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

198

STATE FILE NUMBER

FILED FEB 25 1963

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>		Length of stay in 1b <b>53yrs</b>	c. CITY OR TOWN <b>St. Joseph,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>113 Walter Lane</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>113 Walter Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Neal</b> Last <b>Loubey</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17,</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1909</b>
9. AGE (last birthday) <b>53</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hog Kill Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Armour &amp; Co,</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>George O Loubey</b>	
13b. MOTHER'S MAIDEN NAME <b>Mabel</b>		14. NAME OF HUSBAND OR WIFE <b>Nettie Loubey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of) <b>yes WWII</b>		16. SOCIAL SECURITY NO. <b>59</b>	
17. INFORMANT <b>Nettie Loubey, St. Joseph, Mo</b>		Address	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) <b>Cancer of Lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT-WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>7-2-62</b> to <b>2/17/63</b> and last saw him alive on <b>2-17-63</b> Death occurred at <b>1:35 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>C. S. Grant M.D.</b>		22b. ADDRESS <b>St. Joseph Mo</b>	22c. DATE SIGNED <b>2.19.63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/19/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery St. Joseph, Mo</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Feb. 21, 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Mo. Clerk Goodell</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

C. S. Grant M.D. MEDICAL CERTIFICATION

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Permit issued 2-15-63

0-07

\_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

Signed Charles Stenseth

P. O. Address 17 - 100th St - Y

If this body is not embalmed, fact should be so stated above.